Provider Adjustment, Time limit & Medicare Override Job Aid

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Overview

This Job Aid is designed to help providers learn how to perform adjustments on a claim document. It provides additional information on each of these issues including how to resolve them. The claims adjustment process gives providers an opportunity to request a review or correct a previously processed claim that has either paid or denied. Adjustment requests may be submitted electronically or on paper. An adjustment is used for several reasons including when providers find they need to void/replace a previously paid claim or where adjustments are warranted from triggers within NCTracks that affect the claim (such as retro-eligibility for Medicaid).

Medicaid Resolution Inquiry Form

The Medicaid Resolution Inquiry Form is used to submit Medicaid claims for:

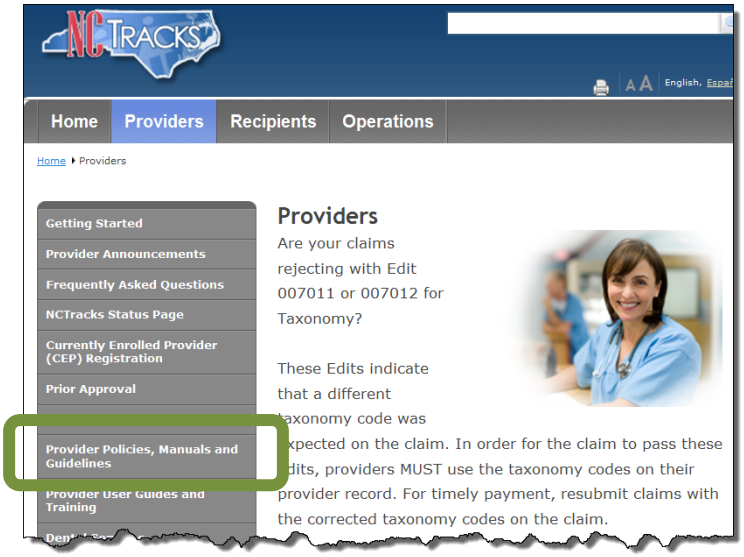
- ✓ Medicare overrides
- ✓ Time limit overrides

When submitting inquiries, always use the **Medicaid Resolution Inquiry Form** located on the NCTracks Provider public page. Overrides will not be issued on claims without this form. Each inquiry requires a separate form and copies of documentation (Explanation of Benefits, vouchers, and attachments). Since these documents are scanned, attach only single-sided documents to the inquiry. **Do not attach double-side documents to the inquiry.**

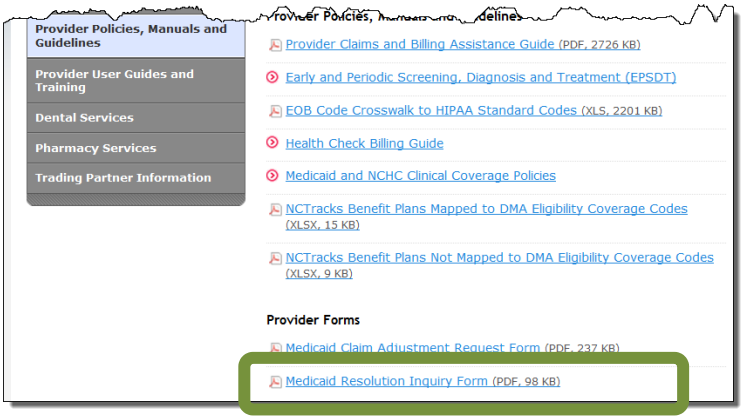
To access the form:

1. Go to the NCTracks Provider Home page: https://www.nctracks.nc.gov/content/public/providers.html

2. Select the **Provider Policies, Manuals and Guidelines** hyperlink on the left-hand side of the screen.



3. Go to the **Provider Forms** section at the bottom of the page.
4. Click **Medicaid Resolution Inquiry Form.**



5. Complete and mail this form to NCTracks at the address specified or displayed on the form.

When submitting inquiry requests, always attach the claim, a copy of any RAs related to the inquiry request, and any other information related to the claim. (Electronic RAs [835 transactions] are not accepted). Each inquiry request requires a separate form and copies of supporting documentation (Explanation of Benefits, vouchers, and attachments).

Medicare Overrides

If the claim is a crossover from Medicare, regardless of the date of service on the claim, you have 180 days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. You must include a copy of the claim and a copy of the Medicare EOB in order to request a time limit override. When a claim for a non-covered Medicare service is denied by Medicare, providers may file the claim to Medicaid and request a Medicare override.

The Medicare voucher with the explanation of the action reason codes must be submitted with the request. When a claim for a covered Medicare service is denied by Medicare, correct and resubmit the claim to Medicare. Override requests for the denial of a covered Medicare service are not acceptable.

Time Limit Overrides

All Medicaid claims (except hospital inpatient and nursing facility claims) must be received by NCTracks within 365 days of the date of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim. If a claim was filed within the 365- day time period, providers have 18 months from the ***last*** Remittance Advice (RA) date to refile a claim**.**

Requests for overrides must document that the original was submitted within the 365-day time period. If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted as a new day claim. The new day claim must have:

- ✓ Exact match of the beneficiary's Recipient ID (RID) or Medicaid ID (MID) number
- ✓ Provider's NPI
- ✓ From date of service
- ✓ Total billed

Claims that do not have an exact match to the original claim in the system will be denied for one of the following EOB Codes:

EOB Code	EOB Code Description
00018	Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to NCTRACKS
02930	POS-claim or reversal greater than 365 days old. Re-file claim (paper) with proper documentation for time limit override.
08918	Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing—a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

When one of the EOB Codes listed above is received, the claim must be submitted on paper along with the **Medicaid Resolution Inquiry Form** and documentation of timely filing.

Since the Division of Health Benefits (DHB) and NCTracks must adhere to all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365- day time period. Examples of acceptable documentation for time limit overrides include:

- ✓ Dated correspondence from DHB or NCTRACKS about the specific claim received that is within 365 days of the date of service
- ✓ An explanation of Medicare or other Third-Party insurance benefits dated within 180 days from the date of Medicare service or other Third-Party payment or denial
- ✓ A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received within the 365-day time limit.

If the claim is a crossover from Medicare or another Third-Party commercial insurance (including a Medicare Part C Advantage Plan insurer), regardless of the date of service on the claim, the provider has 180 days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. The claim should be submitted electronically and a copy of the Third-Party or Medicare EOB can be uploaded as an attachment through the Provider Portal.

Claims that denied for billing errors can be resubmitted within 18 months of the denial without requesting a time limit override.

Adjusting a Claim through the Void and Replacement Process

With the implementation of standard claims transactions to comply with the Health Insurance Portability and Accountability Act (HIPAA), adjustments may be filed electronically. Electronic adjustments are the preferred method to report an overpayment or underpayment to NC Medicaid. There are two separate actions that may be filed:

A provider should use "void" when he/she needs to cancel or submit a refund for a previously paid claim.

- ✓ **Void** – entire claim will be recouped.

A provider should "replace" a claim if he/she is updating claim information or changing incorrectly billed information. This term is interchangeable with adjusting a claim.

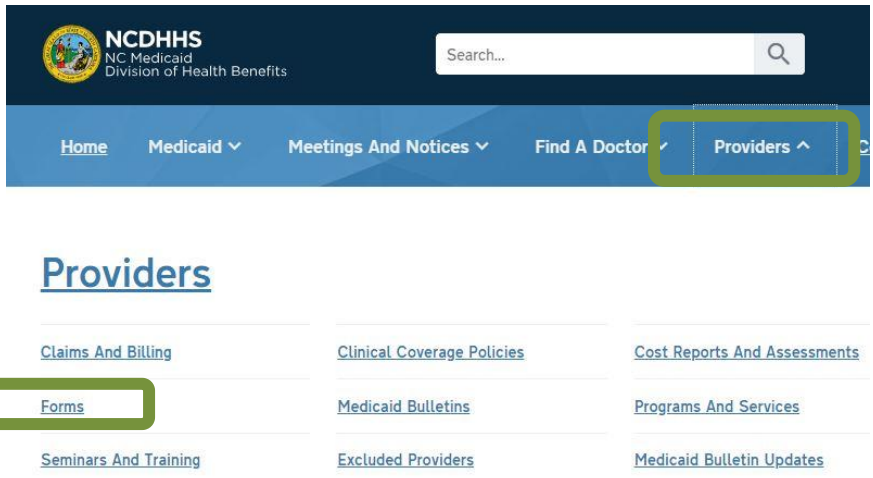
- ✓ **Replacement** – entire claim will be recouped and reprocessed.

Adjustments Related to Third Party Liability (TPL)

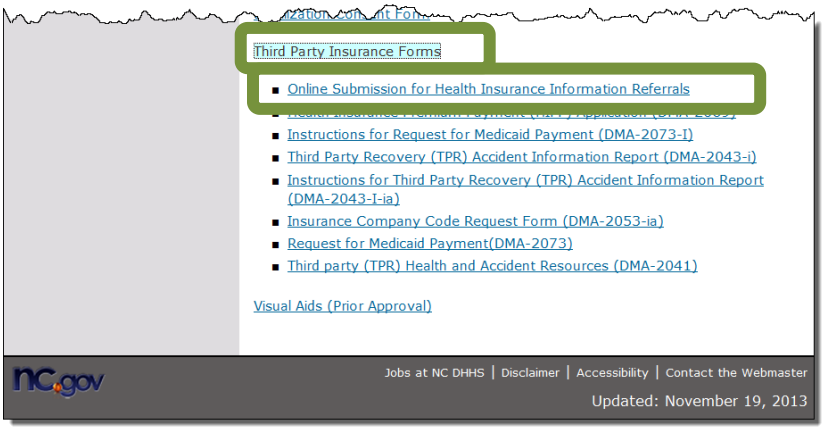
If it is found that a beneficiary has TPL and it was not on file when the claim was processed, it may be necessary for a provider to request an adjustment to the claim to account for the TPL payment.

The first step is to initiate an update to the beneficiary's TPL information by submitting the online NC Provider 2057 Referral form. (This online form is also used if the beneficiary no longer has insurance.)

1. Go to the DHB website: https://medicaid.ncdhhs.gov/
2. Click **For Providers** hyperlink in the top navigation bar
3. Click **Forms** hyperlink on the left navigation menu
4. Select Third Party Insurance Forms



5. Choose **Online Submission for Health Insurance Information Referrals** link https://pierweb.hms.com/pierOnlineApp/tpl/FUSREFNC/memberPortal.htm



Note: Health Management Solutions (HMS) (DHB's Third-Party Liability (TPL) contractor) will update the beneficiary's record within 10 days of receipt of the 2057 referral form. Once the beneficiary's TPL information has been updated, the claim can be resubmitted through the void/replacement process.

An adjustment may also be required if the beneficiary's TPL carrier has changed the original amount of payment. If Medicaid has paid the claim with the TPL amount deducted and the TPL carrier has changed the original paid amount, file a replacement claim with the new TPL payment amount noted.

Adjusting a Claim using the Medicaid Claim Adjustment Request Form

The claims adjustment process affords providers an opportunity to request a review of a previously processed claim. In some cases, an adjustment request must be submitted on paper. Please note, not all denials can be addressed through this process. Primary examples are non-adjustable EOB Codes and CCI/MUE denials discussed further later in this section.

You will have to submit an adjustment request utilizing the **Medicaid Claim Adjustment Request Form.** For example, if you receive:

EOB Code	EOB Code Description
00874	Multiple ER visits not allowed same date of service, same taxonomy qualifier. File adjustment if visits were separate occasion
01871	1 ambulance base can be billed for same DOS, same hour/time. Correct all units/details on claim and resubmit. Multiple respondents, single transport, if there are any exception, file adjustment with records

When requesting a Medicaid claim adjustment, please provide documentation of the medical necessity or extenuating circumstances which support the request for payment.

If a claim has been denied with an EOB **requesting** medical records, the claim should not be submitted as an adjustment request on the adjustment request form. The claim should be resubmitted as a new day claim with the requested records.

Common Denial Codes

The following explanations of benefit (EOB) codes used by N.C. Medicaid/Health Choice are listed below with their suggested resolution(s). Although the suggested resolution(s) are for common denial cases, each claim may pose a unique processing scenario. For further information, contact the NCTracks Call Center for more claim-specific analysis/research.

EOB Code	EOB Code Description	EOB Code Resolution
00069	Bill Medicare PART A Carrier.	Submit claim to Medicare Part A Carrier then resubmit claim to NCTracks reporting payment, include necessary documentation when required.
00153	Ancillary charges are included in per diem rate.	Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
00270	Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or NCTracks Call Center if authorization is correct.	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved. Correct and resubmit the claim.

EOB Code	EOB Code Description	EOB Code Resolution
01108	POS- Denial Due To DUR ALERT	(Informational EOB, no resolution)
01121	POS - Denied due to same week reversal	(Informational EOB, no resolution)
04102	You are attempting to Adjust a Claim that is not on our file or not on our file as previously paid.	Review payment history, correct and resubmit corrected claim or adjustment with documentation as appropriate.
00021	Exact Duplicate	Review payment history and resubmit corrected claim if required. There are different scenarios for exact duplicates. Another resolution would be for the provider to submit an adjustment request with med records to prove the claim was not a duplicate. An override of the audit would have to be placed on the claim by the resolution staff. Just submitting it back as a new day claim may not work in all scenarios
08700	Per legislative mandate this Medicaid claim must be filed electronically for adjudication.	Resubmit electronically or verify all necessary documentation was sent in with the paper claim, adjustment or override request.
08925	Allowable reduced for deductible/patient liability	Prior payment amount exceeds the N.C. Medicaid allowable, or reduces the N.C. Medicaid amount. No action necessary.
09271	Payment is included in DRG reimbursement on first accommodation detail.	Informational EOB - Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
09294	DRG Recoupment	Informational EOB - applies to replacement and void TCN, no resolution required.

If you receive a denial EOB Code with instructions on how to refile (example, bill with modifier 51), correct the claim as stated in the EOB and submit the claim as a replacement claim.

Please note that an adjustment cannot be initiated for any claim that is older than 18 months; these claims can only be recouped.

Correct Coding Initiative /Medically Unlikely Edits (CCI/MUE) Denials

Five EOB Codes have been created to indicate a claim that was denied for a CCI/MUE or other National Correct Coding Initiative (NCCI) edit.

EOB Code	EOB Code Description
09988	Payment of procedure code is denied based on CCI editing.
09953	Payment of Procedure code is denied based on MUE editing.
09954	Payment of procedure code is denied based on correct coding standards editing.
09955	Claim is recouped based on CCI editing.
09956	Detail is recouped based on CCI editing.

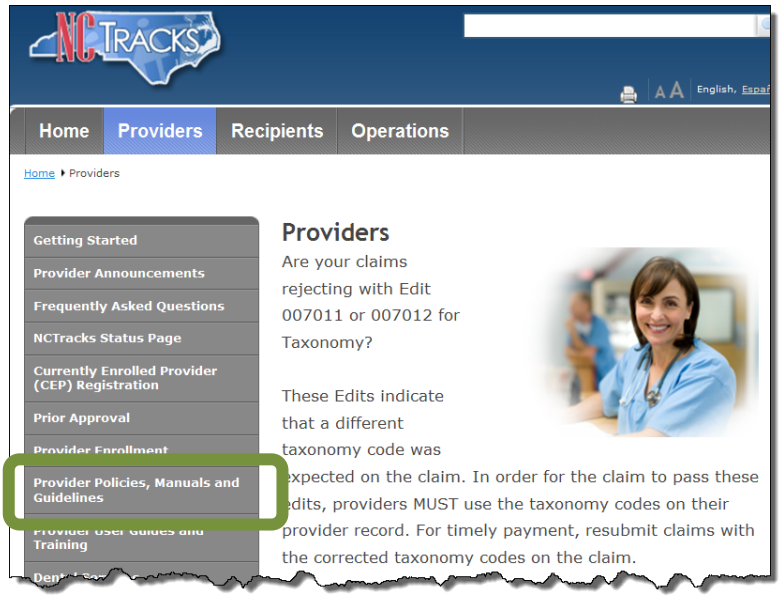
Resubmission of Denied Claims

The **Medicaid Claim Adjustment Request Form** is used to make an adjustment to previously paid claims or certain denied claims. Not all denials require an adjustment request. If adjustments are submitted for certain EOBs, the claim will be denied for EOB 998, which states, “Claim does not require adjustment processing, resubmit claim with corrections as a new day claim,” or EOB 9600, which states, “Adjustment denied; if claim was with adjustment, it has been resubmitted. The EOB this claim previously denied for does not require adjusting.” In the future, resubmit a new or corrected claim in lieu of sending an adjustment request. Please contact the NCTracks Call Center at 1-800-688-6696 if there are any questions on how to resolve a specific denial. Do not use the **Medicaid Claim Adjustment Request Form** to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Use the **Medicaid Resolution Inquiry Form** if you have exceeded the filing time limit.

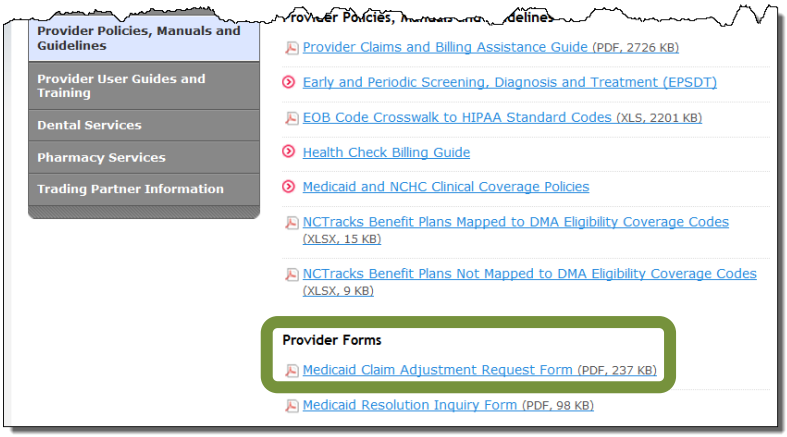
The **Medicaid Claim Adjustment Request Form** is used to make an adjustment to previously paid claims or certain denied claims. When an adjustment request is denied, the provider will receive an EOB code on their RA stating the reason(s) for denial. A list of the EOB codes can be found at the end of this document.

To access the form:

1. Go to the NCTracks Provider Home page: https://www.nctracks.nc.gov/content/public/providers.html
2. Select **Provider Policies, Manuals and Guidelines** hyperlink on the left-hand side of the screen. https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html



3. Go to the **Provider Forms** section at the bottom of the page.
4. Click **Medicaid Claim Adjustment Request Form.**



5. Complete and mail this form to NCTracks at the address specified or displayed on the form.

Pharmacy Claim Adjustments

A **Pharmacy Adjustment Request Form** is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the **Pharmacy Adjustment Request Form** to do the following:

- ✓ Credit Medicaid for a billed and paid prescription that was never dispensed
- ✓ Credit Medicaid for a billed and paid prescription for drugs that were unused
- ✓ Correct National Drug Code (NDC), quantity, days' supply, date of service, billed amount, Rx number, or Third-Party payment

A copy of the Pharmacy Adjustment Request Form can be found on link to Provider Policies, Manuals and Guidelines page - https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

Reconsideration Review Requests

Appealing a Claim Denial or CCI/MUE Denial

Providers can request a reconsideration (appeal) review of a claim denial if an adjustment has been processed and denied. Providers can also request a reconsideration (appeal) review of a CCI/MUE denial. The appeal process requires documentation to support the medical necessity for the service being rendered. Providers may submit a letter requesting reconsideration of either denial to DHB at the address listed below.

Division of Health Benefits
Appeals Unit
Clinical Policy and Programs
2501 Mail Service Center
Raleigh, NC 27699-2501

Before sending a letter requesting reconsideration from DHB, providers should determine if it is appropriate to rebill the claim using a modifier.

EOB Codes and Descriptions

Below are commonly used EOB Codes and their description:

EOB Code	Adjustment EOB Code Description
00014	SERVICE DENIED PER MEDICAL CONSULTANT REVIEW
00017	ADJUSTMENT REQUEST DENIED, BEYOND TIME LIMIT
00049	MEDICAL NECESSITY IS NOT APPARENT
00059	ADJUSTMENTS EQUAL TO OR LESS THAN ONE DOLLAR DENIED
00060	NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES
00063	CORRECT ASSISTANT SURGEONS CLAIM USING INTERNAL MODIFIER 08 IN FIELD 24C OF THE HCFA 1500 CLAIM FORM AND RESUBMIT AS A NEW CLAIM
00074	REIMBURSEMENT AMOUNT EXCEEDS SET DOLLAR AMOUNT
00075	RESUBMIT AS AN ADJUSTMENT AND ATTACH MEDICAL RECORDS, OPERATIVE NOTES, FEDERAL STATEMENTS OR OTHER PERTINENT INFORMATION

EOB Code	Adjustment EOB Code Description
00083	EXCEEDS LEGISLATIVE LIMITS
00084	RECIPIENT IS PARTIALLY INELIGIBLE FOR SERVICE DATES. RESUBMIT A NEW CLAIM BILLING ONLY ELIGIBLE DATES OF SERVICE
00090	DUPLICATE CHARGE DENIED
00363	NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES
00379	HISTORY SHOWS TOTAL OB PACKAGE BILLED WHICH INCLUDES LABS CONSULATIONS AND OFFICE VISITS
00382	OPERATIVE RECORDS RECEIVED HAVE NO DATES OF SERVICE OR CONFLICTING DATES OF SERVICE, CORRECT CLAIM AND/OR RECORDS AND RESUBMIT BOTH AS AN ADJUSTMENT
00394	NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES
00430	CLAIM REFERRED TO THE DIVISION OF HEALTH BENEFITS FOR PROCESSING INFORMATION. THE CLAIM WILL BE RESUBMITTED FOR YOU
00432	HEALTH CHECK SCREENING NOT ALLOWED ON THE SAME DAY AS VISION AND HEARING SCREENINGS
00433	VISION/HEARING SCREEN NOT ALLOWED ON THE SAME DAY AS HEALTH CHECK SCREENING
00524	RECORDS PREVIOUSLY SUBMITTED ARE INSUFFICIENT. RESUBMIT AS AN ADJUSTMENT WITH ATTENDING PHYSICIAN RECORDS SPECIFIC TO DENIED DOS & ORIGINAL RA COPY
00553	TIMELY LIMIT EXCEEDED. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME
00583	MEDICAL SCREENING EXAM FEE PAID IN HISTORY - ER SERVICES DENIED. REFILE CLAIM AS AN ADJUSTMENT AND ATTACH ER MEDICAL RECORDS
00624	DUPLICATE PROCEDURE. SERVICE ALREADY PAID FOR A DIFFERENT DATE OF SERVICE
00716	EXCEEDS ONE PER DAY LIMITATION
00795	SERVICES RECOUPED. DOCUMENTATION SHOWS A DIFFERENT PROVIDER AS ADMITTING/ATTENDING PHYSICIAN. REBILL AS A CONSULTATION
00820	SUBMIT AS ADJUSTMENT WITH LEGIBLE DOCUMENTATION/ ATTACHMENTS
00829	ALL CLAIMS AND RAs RELATED TO INTERIM BILLINGS MUST BE ATTACHED TO ADJUSTMENT REQUEST
00884	REBILL ADJUSTMENT WITH RECORDS DOCUMENTING UNITS
00892	UNITS CUT BACK. LAB RESULTS DO NOT SUPPORT NECESSITY FOR MORE THAN 14 UNITS EPO PER DAY
00893	MEDICAL NECESSITY NOT APPARENT FOR CRITICAL CARE/PROLONGED SERVICES AND CONSULTS ON THE SAME DAY
00896	ADDITIONAL PROCEDURE, SAME DATE OF SERVICE, PAID AT 50 PERCENT OF ALLOWABLE AMOUNT
00899	UNITS CUTBACK. MAXIMUM NUMBER OF UNITS PER DAY EXCEEDED
00900	CLAIM DENIED FOR LACK OF REQUESTED INFORMATION

EOB Code	Adjustment EOB Code Description
00901	NO ADJUSTMENT DUE
00910	REBILL WITH FORM 5016 INDICATING PATIENT LIABILITY AMOUNT
00915	A COMPONENT OF THE EKG HAS PAID ON A PREVIOUS CLAIM. FILE ADJUSTMENT OF THAT CLAIM, COMBINE CHARGES, AND CODE TO ALL INCLUSIVE EKG CODE
00959	MAXIMUM NUMBER OF UNITS PER DAY PREVIOUSLY PAID FOR THIS DATE OF SERVICE
00998	CLAIM DOES NOT REQUIRE ADJUSTMENT PROCESSING. RESUBMIT CLAIM WITH CORRECTIONS AS A NEW DAY CLAIM. IF POS, REVERSE AND RESUBMIT
01106	EXCEEDS LIMIT OF BILLINGS FOR ANTEPARTUM PACKAGE 4-6 VISITS BY DIFFERENT PROVIDERS
01158	ANTEPARTUM PACKAGE RECOUPED. TOTAL OB PACKAGE PAID WHICH INCLUDES ANTEPARTUM CARE
01159	TOTAL OB PACKAGE, WHICH INCLUDES ANTEPARTUM CARE, HAS ALREADY BEEN PAID FOR THIS GESTATION PERIOD
00119	ADJUSTMENT PAID CORRECTLY PER MEDICAID GUIDELINES
00253	ADJUSTMENT DENIED, PLEASE CHECK YOUR RAs FOR PREVIOUS ADJUSTMENT OF THIS CLAIM
00256	CLAIM CANNOT BE PROCESSED. EXPLANATION TO FOLLOW
00258	ADJUSTMENT REFERRED TO DHB FOR ELIGIBILITY DETERMINATION. DO NOT RESUBMIT
00263	ADJUSTMENT DENIED, CLAIM PAID CORRECTLY
00264	ADJUSTMENT DENIED, CLAIM DENIED CORRECTLY
00265	ADJUSTMENT MUST BE FILED ON NCTRACKS ADJUSTMENT REQUEST FORM
00266	ADJUSTMENT DENIED, COMPLETE ALL BLANKS ON THE ADJUSTMENT FORM AND RESUBMIT
00267	RESUBMIT STATING SPECIFIC REASON FOR ADJUSTMENT
00268	REFILE ADJUSTMENT WITH DHB-5016 FORM AND ALL RELATED RAs
00269	BILL MEDICARE PART A CARRIER
00271	REFILE ADJUSTMENT WITH ALL RELATED MEDICARE VOUCHERS. RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF ORIGINAL CLAIMS RA
00272	ADJUSTMENT REQUEST DENIED, ADJUSTMENTS ARE NOT PROCESSED FO RATE CHANGES
00276	FULL RECOUPMENT PER DHB MEMO
00277	FULL RECOUPMENT, PAID TO WRONG PROVIDER
00278	FULL RECOUPMENT, PAID FOR WRONG RECIPIENT
00281	FULL RECOUPMENT, DUPLICATE PAYMENT
00285	ADJUSTMENT DENIED-CHANGE IN PATIENT LIABILITY SHOULD HAVE BEEN ON CLAIM BEFORE SUBMISSION

EOB Code	Adjustment EOB Code Description
00287	ADJUSTMENT DENIED, REFERENCE ONLY ONE CLAIM PER FORM. REFILE ADJUSTMENTS SEPARATELY
00288	ADJUSTMENT DENIED; DHB FILES INDICATE COMMERCIAL INSURANCE. REFILE WITH INSURANCE PAYMENT/DENIAL VOUCHER
00810	ADJUSTMENT DENIED: ADJUSTMENT CAN NOT BE PROCESSED WITHOUT CORRECTED INFORMATION. REFILE ADJUSTMENT WITH A COMPLETE, LEGIBLE, CORRECTED CLAIM COPY
00812	ADJUSTMENT DENIED, PLEASE REFILE WITH ALL RELATED RAs INCLUDING ORIGINAL PROCESSING
03120	PREVIOUSLY BILLED PROCEDURE. SURGERY PERFORMED DURING FOLLOW UP OF ANOTHER SURGERY REQUIRES A MODIFIER. IF CURRENT CLAIM IS ORIGINAL PROCEDURE, REQUEST RECOUPMENT OF PAID DETAIL AND RESUBMIT WITH MODIFIER